Linking Systems of Care for Children and Youth Project

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Ensuring Access to Effective Trauma-Focused Psychotherapy for Children Exposed to Violence: Considerations for Linking Systems of Care Teams

Children exposed to violence (CEV) often need a range of services and supports to facilitate their safety, empowerment, and healing. One need that often goes unmet is for effective, trauma-focused therapy for the child and their non-offending caregiver. Such therapy can reduce symptoms of Post-Traumatic Stress Disorder (PTSD), depression and anxiety, or even prevent such difficulties from developing in the first place. Therapy can also support a healthy relationship between the child and their caregiver, which is one of the strongest predictors of resilience among CEV, and can improve short- and long-term health, educational and justice system outcomes as well. These benefits comprise direct reductions in the suffering and distress of the child and caregiver, but in addition, by teaching healthy coping skills and more adaptive perspectives on emotional expression, gender roles and relationships, therapy can help to disrupt the cycle of violence by reducing the risk of re-victimization and perpetration by CEV in adolescence or adulthood.

So why aren't all CEV able to access trauma therapy? Some communities simply lack effective trauma therapy services for children. Existing services may not be sufficiently child- or teen-specific; may not be adequately trauma-informed or tailored to the needs of children who have experienced specific types of violence/abuse/trauma; may have overly restrictive eligibility criteria, including only serving certain age groups or requiring legal system involvement; may lack sufficient capacity to serve all CEV, as evidenced by long waitlists; and may not utilize evidence-based treatment approaches. In addition, families may also experience numerous logistical barriers to accessing trauma therapy for their children, including difficulty finding services, financial barriers, transportation issues, and difficulty scheduling appointments around school and work schedules. Families who have recently experienced violence/abuse/trauma may also be in survival mode and have other unmet needs that require attention and stabilization before they are able to engage in therapy in the service of their long-term healing.

Many families contend with psychosocial barriers to accessing trauma therapy for their children as well. These include stigma, shame, and fear of judgement and blame regarding the type(s) of victimization they experienced and/or accessing mental health services. Caregivers may also not be aware of the negative impacts of the violence/abuse/trauma on their child or may minimize these due to their own traumatization and emotional responses to the victimization, including self-blame. Similarly, caregivers may be trauma avoidant due to the intense pain that may accompany thinking and talking about the victimization experience, which acts as a barrier to seeking out therapeutic support—for many caregivers, it can feel much easier to try to move on and forget about the traumatic experience. Although this approach may help the family to cope and function in the short-term, it can impede the child's healing process in the long-term. Lastly, caregivers may question whether therapy will actually be helpful to their child, especially if the family has had previous negative experiences with mental health treatment or is concerned about a lack of cultural responsiveness among providers.

So what can practitioners and planners look for to identify appropriate providers of trauma therapy for CEV? Therapists should have a clinical license, for example as a Licensed Clinical Social Worker, or be closely supervised by a therapist who has one. The therapist should have participated in extensive training on trauma treatment generally, as well as on working with children and families who have experienced specific types of violence/victimization. Therapists should also have specific training and experience in working with the appropriate age group, given the vast differences between working with toddlers and teenagers, for example, and feel comfortable and skilled in working with parents and caregivers, as therapy with children is not as effective without a caregiver's active participation.

Trauma therapists for children should also be able to point to the specific assessment tools and processes that they utilize with CEV, as well as the evidence-based treatment models that they employ. Given the high prevalence of polyvictimization among children and teens, therapists should screen children and families for the full range of potential violence and victimization experiences, rather than restricting the focus of treatment to the reason for referral. In addition, they should employ standardized, trauma-informed assessment tools to ask children and families about potentially traumatic experiences and to assess for symptoms of PTSD and other mental health and relational effects of the violence/victimization. Examples of assessment tools for children and teens include the UCLA PTSD Reaction Index; the Trauma Symptom Checklist for Children and Trauma Symptom Checklist for Young Children; the Child PTSD Symptom Scale; and the Mood and Feelings Questionnaire. These tools can also be used to monitor the child's progress in treatment.

As for the treatment itself, many evidence-based interventions for exposure to violence are now available. These include Trauma-Focused Cognitive Behavioral Therapy, which is considered the gold standard in trauma treatment for children due to extensive evidence of efficacy from Randomized Controlled Trials; the Child and Family Traumatic Stress Intervention, which is initiated within 90 days of the most recent traumatic incident to prevent the development of PTSD; Child-Parent Psychotherapy, an

intervention for children ages birth to 3 years old; Cognitive-Behavioral Intervention for Trauma in Schools, a group treatment curriculum for older children; and Structured Psychotherapy for Adolescents Responding to Chronic Stress, a group model specifically for teens that has been used with juvenile justice system-involved populations in particular.

Information about these and other treatment models can be accessed through the website of the National Child Traumatic Stress Network. However, they all have several elements in common. First, they require rigorous clinician training to implement properly. For example, to become a certified Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) therapist, a clinician must receive two full days of training; participate in monthly group consultation calls with a master trainer; and complete the treatment model with at least three clients. In addition, evidence-based trauma treatment models emphasize emotional safety and predictability in the therapeutic relationship; incorporate psychoeducation about trauma and the specific type(s) of violence/abuse that the child experienced; focus on healthy coping with trauma-related symptoms and distress; and incorporate gradual exposure to discussing and processing the traumatic experience. In addition, active, substantial parent/caregiver participation is integral to trauma therapy with children, because they live within and are dependent upon a family system for their well-being. As mentioned, a strong, consistent relationship with a caregiver is critical to children's healing, so caregivers must be engaged in providing support to their child. Caregivers can also benefit from learning the same coping skills as their child and can then reinforce the child's use of those skills outside of therapy sessions.

So what can communities do to increase CEV's access to effective trauma therapy? Some strategies focus on systemic barriers, while others focus on psychosocial barriers. Considering the systems level first, communities can support therapists' access to the specialized training and clinical supervision they need to do this work. Training can focus on trauma treatment generally; on certain types of violence/victimization; on working with children and caregivers, for those who only have expertise in working with adults; on culturally-responsive practice; and/or on particular evidence-based assessment tools and intervention models. Community teams can also systematically identify and address the logistical barriers to children's participation in trauma therapy discussed earlier, and they may wish to consider developing interagency, collaborative grant proposals to fund new or expanded children's trauma therapy services.

As for approaches that target child- and family-level barriers, service providers should be sure to identify and attend to families' other unmet needs, including regarding any safety and financial concerns, so that families can achieve the emotional and financial stability necessary to engage in therapy. Providers can also provide psychoeducation to caregivers on the potential impacts of traumatic experiences on children and how trauma therapy works, including its short- and long-term benefits for children and families and the importance of caregiver participation. In addition, service providers must validate and provide treatment for caregivers' own trauma and emotional distress so they are able to pursue treatment for their child. Lastly, communities and service

providers can implement initiatives to reduce individual and community-level stigma regarding victimization, exposure to violence, and participation in mental health services.

Children and teens who have experienced violence and victimization deserve access to effective trauma-focused mental health treatment that can reduce and prevent emotional suffering and other negative impacts of their exposure to violence. Linking Systems of Care sites and other interdisciplinary collaboratives can work together to ensure that effective trauma treatment is available in every community and all barriers to children utilizing such healing resources are identified and removed.

This document was supported by cooperative agreement number 2018-V3-GX-K014, awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this document are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice, Office for Victims of Crime.